pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail jharper@arborcompany.com
Sent via e-mail mbasham@arborcompany.com
July 29, 2020

Mr. Judd Harper
President of the Management Company
SHP V Willistown, LLC
3715 Northside Parkway NW 300-110
Atlanta, Georgia 30327

RE: Arbor Terrace Willistown
1713 West Chester Pike
West Chester, Pennsylvania 19382
License #: 142450

Dear Mr. Harper:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 16 and 30, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Mia Johnson

Mia Johnson
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *ARBOR TERRACE WILLISTOWN*
License Number: *14245*
Address: *1713 WEST CHESTER PIKE,, WEST CHESTER, PA 19382*
County: *CHESTER*
Region: *SOUTHEAST*

Administrator

Name: *Marianne Basham*
Phone: *6107251713*
Email: *JHARPER@ARBORCOMPANY.COM*

Legal Entity

Name: *SHP V WILLISTOWN LLC*
Address: *3715 NORTHSIDE PKWAY NW 300-110, ATLANTA, GA, 30327*

Certificate(s) of Occupancy

Type: *I-2*
Date: *08/03/2019*
Issued By: *Willistown Twp*

Staffing Hours

Resident Support Staff: *156.25*
Total Daily Staff: *275.25*
Waking Staff: *206*

Inspection

Type: *Full*
BHA Docket #:
Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

12/16/2019 - On-Site: Evelyn Perez, Sandra Wooters

12/30/2019 - On-Site: Evelyn Perez, Sandra Wooters, Alex Goldstein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104*
Residents Served: *84*

Secured Dementia Care Unit

In Home: *Yes*
Area:
Capacity:
Residents Served: *28*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *82*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *35*
Have Physical Disability: *2*

Marianne Basham
Marianne Basham
Executive Director
7/28/20

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in 1st floor SDCU kitchen, 2nd and 3rd floor entertainment room.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Following Inspection, the homes Maintenance Director immediately placed the emergency telephone numbers on the phones in the 1st floor SDCU kitchen, and the 2nd and 3rd floor entertainment rooms. After completion the homes Maintenance Director conducted an audit of all of the phones throughout the community and ensured that emergency telephone numbers were affixed to all of the phones in the home. To prevent this violation from reoccuring, a monthly walk through will be conducted by the homes Maintenance Director to check that all phone stickers are in place. Replacements will be provided as needed.

(See Attachments #1A, 1B, 2, 3)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Director
Printed Name and Title

Date
7/28/20

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The above plan of correction is approved as of 7/29/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/29/20 (Date)

X Implemented

☐ Not Implemented

103d - Storing Food Off Floor

Regulations

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 12/17/19 at 3:30 pm, rice, ketchup, soda, BBQ sauce and ceasar dressing was stored on the floor in the dry storage closet.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

At the time of inspection the home had just received one of its' weekly food deliveries. The order had not yet been put away. The rice, ketchup, soda, BBQ sauce and Caesar dressing were removed from the floor in the dry storage closet. Shelving in the closet was cleaned and reorganized and the above mentioned items were then placed properly on the shelves. To prevent this violation from reoccuring, the dining staff will follow the guidelines as outlined in the Arbor Company's "Food Labeling and Storage" policy. The Dining Director is responsible for monitoring on-going compliance of this regulation, and he or his designee will ensure that the policy is followed when deliveries are received.

*Update related to COVID-19: all non-perishable items in cartons, are delivered to the back service area, and placed on pallets in the service hallway, then unpacked by dietary staff, prior to being put away in dry storage area. Our new Dining Director started in the community on 7/13/20, and will review the Food Labeling and Storage Policy with any new dining team members by 8/10/20.

(See Attachments #4 pages 1&2 AND #4A pages 1&2)

Legal Entity Representative

Marianne Bresham
Signature

Marianne Bresham Executive Director 7/29/20
Printed Name and Title Date

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The above plan of correction was approved by MJ (Initials)

Plan of correction implementation status as of 7/29/20 (Date)

X Implemented
☐ Not Implemented

103f - Refrigerator/Freezer Temps

Regulations

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the freezer located in the Bistro on the 1st floor.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On the day of inspection, a new thermometer was placed in the freezer located in the bistro on the 1st floor by the homes Dining Services Director. To prevent the violation from occurring again, the homes Dining Service Director or designee, will check the freezer and refrigerator in the Bistro, 3x's daily at breakfast, lunch, and dinner time, when the bistro is being serviced, to ensure the thermometer is in place.

(See Attachment #5)

Legal Entity Representative

Marianne Bochum — Signature

Marianne Bochum Executive Dir. 7/28/20 — Printed Name and Title / Date

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X Implemented

☐ Not Implemented

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The yellow water ice in the 1st floor Bistro freezer was opened and unsealed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On the day of survey the yellow water ice in the 1st floor Bistro freezer was removed and discarded. To prevent this from occurring again, the home has posted a notice in the Bistro area, next to the refrigerator, informing all staff and residents that all food items placed in the refrigrator/freezer must be placed in a closed or sealed container, labeled, and dated. To prevent the violation from occurring again, the homes Dining Service Director or designee, will check the freezer and refrigerator in the Bistro, 3x's daily at breakfast, lunch, and dinner time, when the bistro is being serviced, to ensure that food is stored in closed or sealed containers.

(See Attachments #6A, 6B, 6C)

Legal Entity Representative

Marianne Bosham — Signature

Marianne Bosham Executive Director — Printed Name and Title

7/28/20 — Date

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X Implemented

☐ Not Implemented

185a - Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's glucometer was not calibrated to the correct date and time.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On the day of inspection the homes (former) Resident Care Director (RCD) ordered a new blood glucose monitor for, Resident#1 from the pharmacy, and it was calibrated to the correct date and time when delivered. Our new Resident Care Director joined the community in February 2020. He met with the nursing and med tech staff to demonstrate how to calibrate the glucometers and change the date and time when necessary (ie: daylight savings time). To prevent this violation from reoccuring, the Resident Care Director, and Memory Care Director (MCD)complete random checks on all glucometers in their designated areas, on a weekly basis, to ensure that the correct date and time are reflected. The glucometers will also be checked before and after Daylight Savings Time to ensure they reflect the accurate date and time. The RCD and MCD are responsible for oversight of Diabetic Management per the Clinical Protocol.
(See Attachment #7 pages 1&2)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir. 7/28/20
Printed Name and Title Date

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Plan of correction implementation status as of 7/29/20 (Date)

[X] Implemented
[ ] Not Implemented

The above plan of correction was approved by (Initials)

187c - Refusal of Medication

Regulations

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #2, refuses medications frequently. The home documented refusals on 12/10, 12/11, 12/12, 12/14, 12/15, 12/16, 12/20, 12/24, 12/26 and 12/30/19. The home did not document the physician's response regarding the resident's refusals.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Refusals for resident #2 were discussed with the Primary Care Provider. Medications for resident #2 have since been changed to PRN (as needed) by the PCP on 1/6/20, 1/23/20, 2/24/20 and 3/23/20. To prevent this violation from occurring again, our Regional RN Clinical Specialist provided education to nursing and medication tech staff regarding the expectations related to their documentation on 01/29/2020. The new Resident Care Director followed up with the nurses and medication techs, as well,stating that if any resident refuses a medication, they are to immediately notify the LPN/Shift Supervisor or the Shift Lead. That person is responsible to document the refusal in the residents chart notes, contact the PCP, and document the response received. Both the Resident Care Director and the Memory Care Director are responsible for reviewing the QuickMAR Dashboard on a daily basis to ensure compliance.
(See Attachment#8 pages 1&2)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir. 7/28/20
Printed Name and Title Date

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X Implemented
Not Implemented

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190a - Completion Medication Course

Regulations

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff persons A and B, who have not successfully completed the Department-approved medications administration course, administered medications to residents. Initial 12/7/18 Certification to administration of creams, etc., Diabetes 4/26/19.

Annual Practicum, started with 1 med observation/MAR review on 9/20/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The community had previously contracted with an outside provider to certify and train our Med Techs until we hired our former Resident Care Director, who was a DHS Medication Administration Trainer. Although Staff persons A and B had previously completed their training, the paperwork was disorganized, and out of order. Following the first day of inspection, the former Resident Care Director/DHS Medication Administration Trainer completed a re-certification for staff person A on 12/19/19, and also completed a re-certification for Staff person B on 12/17/19, in order to be in compliance. This training was observed and confirmed by the Staff persons. The RCD/DHS Medication Administration Trainer is no longer employed by the home as of January 2020, and going forward this home is enlisting the services of a contracted DHS Medication Administration Trainer.
(See Attachment#9 pages 1 to 7 And Attachment #10 pages 1 to 8)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir. 7/28/20
Printed Name and Title Date

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X Implemented
Not Implemented

190c - Record of Training

Regulations

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff persons A and B, does not indicate that the practicum training was completed by 12/7/19. No name on the practicum student certificate.

The home's medication administration training record for staff persons C and D Annual Practicum includes two med observations and two MAR reviews but no documentation. In addition, there is no name to the certificate, date re-certified or the trainer's signature.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The community had previously contracted with an outside provider to certify and train our Med Techs until we hired our former Resident Care Director, who was a DHS Medication Administration Trainer. Although Staff persons A and B, as well as Staff persons C and D, had previously completed their training, the paperwork was disorganized, and out of order. Following the first day of inspection, the former Resident Care Director/DHS Medication Administration Trainer completed re-certifications for staff person A on 12/19/19, for Staff person B on 12/17/19, for Staff person C on 12/18/19, and Staff person D on 12/16/19, in order to be in compliance. This training was observed and confirmed by the Staff persons. The RCD/DHS Medication Administration Trainer is no longer employed by the home as of January 2020, and going forward, this home is enlisting the services of a contracted DHS Medication Administration Trainer.
(See Attachment#9 pages 1 to 7 And Attachment #10 pages 1 to 8 And Attachment #11 pages 1 to 9 And Attachment #12 pages 1 to 10)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir. 7/28/20
Printed Name and Title Date

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X Implemented
Not Implemented

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224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3, was admitted to the home on 06/30/19; however, the resident's preadmission screening form was completed on 07/22/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Former Resident Care Director initially assessed Resident #3 on 6/20/19, at request of the potential resident, seeking admission to the community. Resident/POA took financial possession of apartment on 6/30/19. Former Resident Care Director filled in the Preadmission Screening form on day of the physical move-in, on 7/22/19. Although date of occupancy was noted on the contract, to prevent this violation from occurring again, all preadmission screenings will be completed by Resident Care Director (RCD) and/or Memory Care Director (MCD) within 30 days prior to move-in/physical occupancy date. The Resident Care Director and the Memory Care Director will complete a chart audit upon admission of all future residents to ensure compliance. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5)

Legal Entity Representative

Marianne Bashom
Signature

Marianne Bashom Executive Dir. 7/28/20
Printed Name and Title Date

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The above plan of correction was approved by MJ (Initials)

Plan of correction implementation status as of 7/29/20 (Date)

X Implemented
☐ Not Implemented

225a - Assessment 15 Days

Regulations

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3, was admitted on 06/30/19; however, the resident's assessment was not completed until 08/05/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The DME for Resident #3was obtained and RASP was completed by previous Resident Care Director (RCD). Resident/POA took financial possession of apartment on 6/30/19. Although date of occupancy was noted on the contract, resident #3 did not move into the community until 7/22/19. Current RCD completed status change RASP on resident #3 based on status change. To prevent a future violation from happening again, and ensure all dates are correct moving forward, the RCD/Memory Care Director (MCD) will complete a chart audit of the new resident charts upon admission for all future residents to ensure on-going complianace. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5)

Legal Entity Representative

Marianne Bosham
Signature

Marianne Bosham Executive Dir. 7/28/20
Printed Name and Title Date

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X Implemented
Not Implemented

227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2, was evaluated to need compression stockings to lower legs on 12/12/19. As of 12/30/19 the RASP has not been updated to provide support for this new need.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Former Resident Care Director completed an "Assessment and Support Plan Update and Changes" form on 12/31/19 for Resident #2 to reflect the need for compression stockings. New RCD completed the Annual Assessment due in February 2020, and indicated the need for the compression stockings on page 6 of the new RASP. To prevent a repeat violation, the Resident Care Director, Memory Care Director, and Wellness Nurse will utilize the "Assessment and Support Plan Update and Changes" form when there is a need to update the support plan for medical, dental, vision, hearing, mental health or other behavioral care services, or referrals for outside services are received. If there is a need for a "significant change," the RASP will be updated appropriately.
(See Attachments #14 pages 1 to 12)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir. 7/28/20
Printed Name and Title Date

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X Implemented

Not Implemented

231b - Medical Evaluation

Regulations

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #4 admitted to the Secure Dementia Care Unit (SDCU) on 7/15/19. DME dated 6/17/19 does not indicate the need to resident in an SDCU.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

When the decision was made to move into the community, the Senior Care Counselor obtained the DME from the family. Standard operating procedure is for the DME to be reviewed by either the Memory Care Director (MCD) or the Resident Care Director (RCD). Under normal circumstances, one of our Nurses, either the MCD or RCD would contact the Physician that completed the DME, and make any necessary changes that need to be documented with the Physician's permission. A chart note would be entered. When Resident #4 was admitted to the SDCU ON 7/15/19, the DME dated 6/17/20 did not indicate the need for the Resident to be admitted to the SDCU.Based on the amount of time that had lapsed between receiving the DME from the family and admitting the Resident, an error occurred. Going forward, to prevent a similar violation, the MCD or RCD will complete a chart audit of the new resident charts upon admission for all future residents. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5)

Legal Entity Representative

Marianne Bosham
Signature

Marianne Bosham Executive Dir. 7/28/20
Printed Name and Title Date

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Plan of correction implementation status as of 7/29/20 (Date)

X Implemented
[ ] Not Implemented

The above plan of correction was approved by (Initials)

231e - No Objection Statement

Regulations

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #4, was admitted to the Secure Dementia Care Unit (SDCU) on 07/15/2019. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #5, was admitted to the SDCU on 7/31/19. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

In both cases, regarding Resident # 4 and Resident #5, the Senior Care Counselor (SCC) did have a copy of the written consent form that was obtained during the admission process, with the signature of the Resident's designated person; however, neither form had the Resident's signature on it. Because move-in day can be a long day, the SCC will sometimes spread the paperwork out so it is not overwhelming to the Resident. In doing so, the forms were obviously filed away, and were never signed by either Resident. After a few attempts following our survey, both signatures were obtained. Going forward to avoid repeating this violation, the Memory Care Director (MCD) will complete a chart audit of the new resident charts upon admission for all future residents to ensure on-going complianace. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5 And Attachment#15 pages 1 & 2)

Legal Entity Representative

Marianne Bashaw
Signature

Marianne Bashaw Executive Director 7/28/20
Printed Name and Title Date

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X Implemented
☐ Not Implemented

233a - Lock Approval

Regulations

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the locking system used on the exit doors from the SDCU.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Although we had the proper paperwork showing approval previously, on the day of survey, we were unable to locate it. Immediately following our survey,we located the paperwork in our emergency binder; however, it was in the wrong section of the binder. The paperwork is dated July 29, 2013 and August 21, 2013 when the community was formerly known as Solana Willistown.
(See Attachment #16 page 1 & 2)

Legal Entity Representative

Marianne Bosham
Signature

Marianne Bosham Executive Dir. 7/28/20
Printed Name and Title Date

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Plan of correction implementation status as of 7/29/20 (Date)

[X] Implemented
[ ] Not Implemented

233b - Lock Manufacturer Statement

Regulations

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the locking system, verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated. Requested, not available.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Although we had the proper paperwork showing approval previously, on the day of survey, we were unable to locate it. Immediately following our survey,we located the paperwork in our emergency binder; however, it was in the wrong section of the binder. The paperwork is dated July 29, 2013 and August 21, 2013 when the community was formerly known as Solana Willistown.
(See Attachment #16 page 1 & 2)

Legal Entity Representative

Marianne Bosham
Signature

Marianne Bosham Executive Dir.
Printed Name and Title

7/28/20
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 7/29/20 (Date)

The above plan of correction was approved by MC (Initials)

Plan of correction implementation status as of 7/29/20 (Date)

X Implemented
☐ Not Implemented

234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 07/15/2019. However, initial support plan was completed on 07/25/2019.

Resident #5, was admitted to the Secure Dementia Care Unit (SDCU) on 07/31/2019. However, initial support plan was completed on 7/31/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

At the time of inspection it was noted that neither Resident #4 or Resident #5 had a support plan in place as required within 72 hours prior to admission. During follow-up with the Memory Care Director, it was noted that she had made the mistake of thinking that our company's assessment form was acceptable until she filled out the support plan in it's entirety after getting to know the Residents better. She was advised that although our assessment is thorough, we use the state support plan as required, and the timing of completing the support plan is within 72 hours prior to admission so the staff members are able to best serve the Resident. She received clarity and understands she made an error. She has completed the RASPS timely since this error. to prevent this violation from happening again, the Memory Care Director (MCD) will complete a chart audit of the new resident charts upon admission for all future residents to ensure on-going complianace. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5 And Attachment#15 pages 1 & 2)

Legal Entity Representative

Marianne Basham
Signature

Marianne Basham Executive Dir
Printed Name and Title

7/28/20
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251b - Record Entries Legible

Regulations

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The date on the preadmission screening for resident #6 is override and illegible.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The former RCD had signed off on the preadmission screen for Resident #6, and the date of the screen is illegible. Although we cannot determine why she wrote over it, we will ensure compliance going forward, by utilizing our chart audit forms to complete our new admissions. The RCD, MCD, ED, and Business Office Director will complete all necessary paperwork upon admission, and conduct monthly audits to keep paperwork organized and compliant.
(See Attachment #13 pages 1 to 5)

Legal Entity Representative

Marianne Basham
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Marianne Basham Executive Dir. 7/28/20
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252 - Record Content

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:
   2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
   3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #4's record does not include her hair color, eye color or identifying marks. Resident #2's record does not contain a photograph that is no more than two years old, resident hair color, eye color or significant marks.

Resident #7's record does not contain residents preadmission screening and cognitive preadmission screening.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Resident records listed above, along with all current records of the Residents in the community, were reviewed by the RCD, the MCD, the Executive Director, and the Business Office Director. Upon completion of the full audit, we determined that in addition to the Resident's Face Sheets, we are utilizing a "Resident Photo/Personal Identification Page" to cover all of the contents required to be part of the Resident Record. Using these documents will prevent similar violations from occurring again.
Resident#7 moved into the community when it was managed by a different company, before transitioning to the Arbor company. We cannot go back and create the preadmission screen; however, we do have a plan in place to prevent this violation from happening again. The MCD or RCD will complete a chart audit of the new resident charts upon admission for all future residents. The Business Office Director will complete a monthly chart review, selecting 10% of the charts, and will include both Personal Care and Memory Care charts. The RCD, MCD, and Business Office Director will update the chart audit forms with each use to prevent this violation from reoccurring.
(See Attachment #13 pages 1 to 5)
(See examples - Attachment#17 pages 1 & 2)

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